FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
JUNE 12, 2000

Carriers

Medicare Integrity Program

Medical Review
Medicare Secondary Payer
Benefit Integrity
Provider Education and Training
Productivity Investments

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Medical Review (Carrier and DMERC)

The Medical Review (MR) Budget and Performance Requirements (BPRs) reflects the principles, values, and priorities for the Medicare Integrity Program (MIP). Program Integrity's primary principle is to pay claims correctly. In order to meet this goal carriers must ensure that they pay the right amount for covered services rendered to eligible beneficiaries by legitimate providers. HCFA follows four parallel strategies that assist us in meeting this goal: 1) preventing inappropriate payments through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

The MR BPR also supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that carriers reduce the error rate identified by the Office of Inspector General's Chief Financial Officer (CFO) audit. Both the GPRA and NPR instruct carriers to increase the effectiveness and improve the efficiency of medical review.

The MR Budget and Performance Requirements form the basis of the Contractor Performance Evaluation (CPE) for MR units. The CPE core standards support HCFA's Program Integrity strategy. HCFA's national objectives and goals of the CPE are as follows: 1) Increase the effectiveness of medical review activities; 2) Exercise accurate and defensible decision making on medical reviews; 3) Effectively educate and communicate with the provider and supplier community; 4) Collaborate with other internal components and external entities to ensure correct claims payment, and to address situations of fraud, waste, and abuse. Therefore, carrier budget requests should ensure implementation of all MR program requirements in Program Integrity Manual in addition to those specified in this document.

Each carrier should provide the ***supporting documentation in Attachment 3*** of the FY 2001 BPRs.

Medical Review Program Goals and Directions

Medical Review Program Point of Contact

An effective Medical Review program begins with the strategies developed and implemented by senior management staff. Carriers must name a medical review point of contact that will act as the primary contact between the carrier and HCFA concerning the carrier's entire medical review program. Although carriers have the discretion to title this position however they choose, for purposes of this document the individual shall be called the "MR Manager".

Quality Improvement Program

The carrier must assure the implementation of an effective Quality Improvement Program. The carrier must develop and implement a Quality Improvement (QI) program to assure that the decisions made by medical review staff are accurate and consistent among MR staff. The QI program requires physician participation to determine the accuracy of medical review decisions. Inter-reviewer reliability and accuracy is a critical portion of the QI program. The QI program must test and improve inter-reviewer reliability. The program must assure a thorough and efficient medical review process. The QI program must include a documented process for the review of complex cases and cases that represent a significant vulnerability to the Medicare program and have a significant provider impact. This process must assure that the appropriate professional personnel are available to review such cases. The carrier may wish to determine an internal claim processing error rate. The QI program must assure that the carrier has good management practices. One way that carriers can ensure good management procedures is to become ISO 9000 certified[1] or to

[1]For more information concerning ISO 9000 certification, on the World Wide Web go to www.ASQ.org, or call 1-800-248-1946.

undergo a third party validation process. The carrier must consider the appeals reversal rate when making decisions concerning the medical review process. The medical review manager should work to resolve conflicts between the appeals and medical review areas. The medical review manager should communicate with other Medicare contractors concerning best practices of the medical review process. The medical review manager must submit a report of findings for the QI program. This report must be submitted 30 days after the close of the second and fourth quarters. This report must be entitled "Medical Review Quality Improvement Program" and include, at a minimum, the results of inter-reviewer reliability studies, a description of the medical review process, a synopsis of management practices and any actions taken as a result of the carrier's findings. The report must be submitted to the Regional Office and copied to the Central Office at MROperations@cms.hhs.gov .

Communication with Beneficiaries and Providers

Beneficiaries and Providers are our customers. Therefore, medical review staff is expected to provide the appropriate level of customer service to both providers and beneficiaries. Medical review personnel must communicate effectively with providers and beneficiaries concerning the determinations made during the medical review process. This level of communication may require in-person, telephone or written communications in order for the customer to fully understand the medical review processes and procedures, as well as medical review determinations. Medical review personnel must be fair, responsive, and courteous when addressing all inquiries. Effective communication with the beneficiaries and providers we serve is critical. In addition, MR personnel should provide adequate feedback to customer service personnel so that they can interpret and explain medical review decisions when questioned by the beneficiary or the provider. Conversely, MR personnel should obtain feedback from customer service representatives regarding beneficiary and provider comments about medical review policies, processes, and decisions.

MIP-PET in Medical Review

MIP-PET is remedial and concentrates primarily on providing feedback to providers based on data analysis and medical review results. MIP-PET activities include one on one feedback for provider specific errors; community-wide feedback for widespread errors; and general information about Program Integrity activities. Usually this feedback can be provided best by the Program Integrity component most familiar with the work. For instance, medical review personnel would be able to provide the most accurate feedback concerning issues related to medical review.

For FY 2001, carriers should **not** include costs associated with medical review related to provider outreach or education activities in their MR request. Although MIP-PET activities are an integral part of the MR program, these costs must be included in the Medicare Integrity Program Provider Education and Training (MIP PET) BPR.

Internal Coordination

Interaction and coordination among the carrier's appeals unit, fraud unit, medical review unit, provider enrollment unit, and provider relations unit is essential in determining the appropriate actions to be taken to resolve Program Integrity issues. The goal of this coordinated, inter-disciplinary effort is for all parties to work as an informed team to arrive at an agreed upon resolution of outstanding Program Integrity concerns/issues. Carriers must coordinate, interact, and share information through monthly meetings with internal contractor staff from the fraud, medical review, provider enrollment, and provider relations units. The MR manager must have readily available copies of the minutes of these inter-disciplinary meetings for Regional Office and Central Office review.

Workload Information and Documentation

For HCFA review purposes, the carrier must assure the presence of workload information and documentation at each site for those carriers that retain multiple medical review processing sites. At a minimum, this information must include workload information captured by the Interim Expenditure Report (IER). Additionally, the carrier must maintain collective workload information at each site. Carriers that operate in multiple sites may be requested to provide this information on an on-going basis. The Regional and Central Office may request workload information separately for each field office.

Focus on Program Vulnerabilities

The carrier must make every effort to increase the effectiveness of medical review payment safeguard activities. The carrier should focus reviews to those areas of program vulnerability identified through data analysis and by the Office of the Inspector General through their reports and the CFO Audits. HCFA will inform the carrier on a semi-annual basis of these reports and other areas of program vulnerabilities identified at the national level.

Random Review and the Comprehensive Error Rate Testing (CERT) Program

As previously stated Medicare's program integrity goal is to pay claims right. To assure that only covered claims are paid, the FY 2001 BPR maximizes the amount of random and data driven prepayment review. Specifically, each carrier should develop and implement a random prepayment review process in addition to their data driven medical review process. Random review places the provider community on notice that every claim has the potential to be reviewed. However, the implementation of the Comprehensive Error Rate Testing (CERT) program replaces the requirement for random review. Therefore, once the carrier has implemented the CERT program it must cease its random review process.

Advance Determination of Medicare Coverage for Certain Customized Items of DME

DMERC's budgets should include funds for activities associated with providing advance determinations of Medicare coverage for certain customized items of DME.

Progressive Corrective Actions

Contractors are to continue to analyze data, complaints, and other sources of information to focus their medical review efforts. However, once the information is analyzed, non-compliance with Medicare rules and regulations should be prioritized depending on the severity of the non-compliance and the magnitude of risk to the Medicare program. Employ a variety of MR tools depending upon the severity of the billing error. These tools range from provider feedback and education to the review of a statistically valid random sample of claims for the purpose of extrapolating an overpayment. Analysis of a small sample of claims, i.e., a probe review, will suffice to determine if a more extensive review must be undertaken. However, the carrier must provide feedback to the provider prior to proceeding with additional corrective action(s). Provider feedback is critical in eliminating billing errors to the Medicare program. Provider feedback is not required in instances of suspected fraud when the provider is referred to your fraud unit. (Note: Provider feedback and education is considered a MIP PET activity.)

Medical Review Activities

The carrier's medical review strategy must ensure that the appropriate level of review is performed. Ensure that the least burdensome, most efficient level of review is utilized. For example, do not conduct routine reviews when the system is capable of addressing the review in an automated fashion. Likewise, do not perform complex reviews when the medical review determination can be made at the routine review level. Carriers must exercise efficiency in meeting workload goals. The carrier must ensure that prepayment review activities are given preference over postpayment review activities. Therefore, allocations for postpay review must never exceed allocations for prepay review. Prepay medical review should begin on the first day of FY 2001 and continue throughout the year. In order to assure that a carrier's workload is stable throughout the year, carriers are expected to perform all types of prepayment and postpayment review each and every month. The MR manager must submit a report outlining their annual MR strategy to the Regional Office and copy the Central Office at MROperations@cms.hhs.gov by close of business November 1, 2000. This report should include intended areas for focusing the carriers medical review resources and the types of review anticipated.

Prepayment Claim Review Activities

Prepayment review is divided into three distinct types of reviews. These three types are defined as:

- **Automated Review**

This review does not involve any human intervention whatsoever. It occurs when a claim/line passes through the carrier's medical review system edits or any adjunct system containing medical review edits **AND** is denied in whole or in part because the service(s) is not covered (including not reasonable and necessary).

- **Routine Manual Review**

  Routine review requires hands on review of the claim and/or any attachment submitted by the provider, excluding the evaluation of medical records for the purpose of preventing payments of non-covered or incorrectly coded services. This review would include any other existing documentation internal to the carrier, such as the claims history file or policy documentation. Experienced and specially trained staff should perform these reviews.

- **Complex Manual Review**

  Complex review goes beyond the routine manual review process to include the evaluation of medical records or any other documentation, the review of which requires professional medical expertise, for the purpose of preventing payments of non-covered or incorrectly coded services. Professionals must perform complex manual reviews, i.e., at a minimum, by LPNs.

Automated Review (Activity Code 21001)

In FY 2001, MR units are expected to make every effort to increase their amount of automated medical review. For example, wherever possible, each carrier must implement National Coverage Policies or Local Medical Review Policies (LMRP) through systems edits. When services are excluded by statute or National Coverage Policy, or when National Coverage Policies or LMRP states that a service is never covered systems edits must be developed to automatically deny these services.

Report the costs associated with automated review including personnel to install and activate supplemental edit software in Activity Code 21001. In the workload section of the CAFMII in Activity Code 21001, carriers should report the number of claims denied in whole or in part in both Workload 1 and Workload 2 (i.e., the same number should appear in Workload 1 and Workload 2). To the extent the carrier can report lines denied, they should be reported in Workload 3.

Routine Manual Reviews (Activity Code 21002)

In FY 2001, there will be no workload goal for routine manual reviews for carriers. Instead the carrier shall implement the most efficient medical review standard. Only in those instances where reviews cannot be automated shall the carrier conduct routine review. However, in FY 2001, the DMERCs shall perform prepayment review, both routine and complex combined, on no more than 14% of the total claims volume processed per month.

For claims that suspend for routine manual review, each carrier shall review the claims using the carriers internal review guidelines. To the extent possible, these reviews should focus on those areas identified as program vulnerabilities. Program vulnerabilities can be identified by HCFA or by the carrier. Experienced and specially trained staff should perform these reviews.

Report all costs associated with routine manual reviews in Activity Code 21002. In the workload section of the CAFMII in Activity Code 21002, report the number of claims reviewed in Workload 1. Carriers should report number of claims denied in whole or in part in Workload 2. To the extent the carrier can report lines denied, they should report this number in Workload 3.

Complex Manual Reviews (Activity Code 21003)

The purpose of complex manual review is to determine if the underlying medical documentation supports the services billed. The carrier's workload for complex manual review is established as a goal to be obtained over the next two years. Carriers that have already met or exceeded this goal must, at a minimum, maintain their current

workload. The workload goal for focused complex manual reviews is 0.35% of the total claims volume processed per month. In FY 2001, the DMERCs shall perform prepayment review, both routine and complex combined, on no more than 14% of the total claims volume processed per month. Carriers shall perform complex manual reviews directed toward identified areas of program vulnerabilities. Program vulnerabilities can be identified by HCFA or by the carrier.

In addition to the carrier's focused complex review workload of 0.35%, the carrier must perform random complex manual reviews on 0.01% of the total claims volume processed per month. The carrier must perform random reviews every month until the implementation of the Comprehensive Error Rate Testing (CERT) program. The CERT program will replace the requirement for random reviews. Random review is defined as every otherwise payable claim with submitted charges above $10 in the total universe of all claims has the exact same probability of being selected for review. If the carrier cannot perform random review as defined but can perform random review on the vast majority of claims, the carrier must submit their plan to perform modified random review to the regional office for approval. If the carrier is unable to perform random review or modified random review as approved by the regional office, the carrier must perform an equal percentage (0.01% of the total claims volume processed per month) of random postpay review on a timely basis, that is, the postpay review must be completed within three months once the claim is selected for review. Random complex manual reviews should be considered a part of the carrier's normal prepayment review process and workload. Carriers should take steps to increase the receipt of requested documentation. Professionals must perform complex manual reviews, i.e., at a minimum, LPNs. Physician input must be provided when necessary to make accurate review decisions.

Report all costs associated with complex reviews in Activity Code 21003. In the workload section of the CAFMII, in Activity Code 21003 report the number of claims reviewed in Workload 1. Carriers should report the number of claims denied in whole or in part in Workload 2. To the extent the carrier can report lines denied in whole or in part, they should report this number in Workload 3.

Postpayment Review Activities (Activity Codes 21004, 21005, 21006)

In FY 2001, the workload for postpayment review is established as a goal to be obtained over the next two years. Carriers that have already met or exceeded this goal must, at a minimum, maintain their current workload. The carrier's workload goal for postpayment review is 0.04% of the total claims volume processed per month. DMERCs shall perform postpayment review on no more than 0.10% of the total claims volume processed per month. These reviews can be conducted either onsite or in-house. For claims that suspend for routine manual postpay review, each intermediary shall review the claims using the intermediaries internal review guidelines. Experienced and specially trained staff should perform these reviews. Professionals must perform complex manual postpay reviews, i.e., at a minimum, LPNs. Physician input must be provided when necessary to make accurate review decisions.

Report all costs associated with the postpayment medical review of claims, e.g., sampling design and execution; claims examination, reviewing medical records and associated documentation; assessing overpayments; and contacting providers to notify them of overpayment assessment decisions.

Report all costs associated with all postpayment claims review, on-site postpayment claims review, and in-house postpayment claims review in Activity Codes 21004, 21005, and 21006, respectively. In the workload section of each CAFM II code, report the total number of claims reviewed on a postpayment basis in Workload 1, report the total number of claims denied in whole or in part in Workload 2. Carriers must keep a record of their postpayment review workload including number of claims denied in total or in part, the total number of CMRs completed during the fiscal year, the amount of overpayments identified, and the amount of actual recovery.

Data Analysis Activities (Activity Code 21007)

Each carrier should conduct sophisticated data analysis to identify potential errors (formerly called aberrancies). This data analysis effort must be coordinated with the fraud unit to ensure that corrective actions, such as medical record reviews, initiated by either the MR unit or the Fraud Unit do not overlap or unduly burden the provider.

In addition to the activities described in the Program Integrity Manual carriers must accommodate the following data analysis activities:

- Refine data analysis approaches, methods, and software to improve the identification of potential errors. Once data analysis has revealed a potential error, the carrier must determine if the potential error represents a widespread problem or a concentrated problem, as this will guide the carrier's selection of appropriate corrective actions.

- Utilize data based upon ordering or referring provider. This type of data analysis is particularly useful in detecting aberrant ordering patterns of certain providers.

- Identify problems that might require the development of LMRP. LMRPs must be developed for those items or services that pose a high risk to the Trust Fund (i.e., high dollar, high volume). The carrier's data analysis will assist in prioritizing which items/services require an LMRP and which can be managed through individual claims determination.

- Collaborate with MIP-PET to distribute Comparative Performance and Billing Reports (CPBR). These reports should focus on providers that could benefit from these reports, especially those providers whose billing patterns are questionable or aberrant. These reports should include, at a minimum, information concerning the provider's utilization in relation to the appropriate local and national peer group. For laboratory providers, the CPBR should be divided into two categories; one for laboratory tests related to end-stage renal disease and the other for laboratory tests not related to end stage renal disease. Additionally, these reports should be furnished to providers upon request.

Report all costs associated with data analysis activities in CAFMII Activity code 21007 except for data analysis associated with law enforcement support. Data analysis costs associated with law enforcement support should be reported using CAFMII Activity code 21009 for MR law enforcement support or 23006 for Benefit Integrity law enforcement support. There is no final claims workload to be reported for this activity.

Policy Development Activities (Activity Code 21008)

The Contractor Medical Director's primary responsibility is the development of Local Medical Review Policies. Report all costs associated with the development and implementation of local medical review policies. At a minimum, carriers must perform the following activities:

- In general, Local Medical Review Policies (LMRP) must be developed for those services that demonstrate a significant risk to the Medicare trust fund. These services include identified or potentially high dollar and/or high volume services. Special consideration should be made to the development of LMRP to assure beneficiary access to care. CMDs should continue to make individual claim determinations for those services that are not addressed by an LMRP.
- Coverage determinations must never be published in the contractor bulletin unless those determinations were developed through the local medical review policy or national coverage policy development process.

- Assure that the LMRP development process, including the template development process, remains open to the public. Template policy development must be receptive to concerns of the general public. Carriers must include public meetings to discuss draft LMRPs prior to presentation at the Carrier Advisory Committee.

- Collaborate on the development of LMRP through clinical workgroups.

- Conduct training sessions to educate medical review staff about LMRPs and internal medical review guidelines.

- Conduct training sessions to educate customer service and provider representatives about LMRPs and internal medical review guidelines.

- Employ at least one full time CMD. The Regional Office may make exceptions for those carriers with extremely low claims volume.

- Post clearly marked draft and final Local Medical Review Policies on your internet website in accordance with the guidelines stated in the program management provider education and training BPR. The website must be updated as policies are developed or finalized. Implement the capability to accept electronic comments related to these policies by January 1, 2001. The MR manager must submit the internet address of the website to the Regional Office and copy the Central Office at MROperations@cms.hhs.gov.

- The carrier must support the Local Medical Review Policy Analysis Contractor (Kathpal Technologies, Inc.) in their efforts. At a minimum, continue to send revised final and final LMRP to ContractorPolicy@cms.hhs.gov .

Report all costs associated with LMRP activity in CAFMII Activity code 21008. Report the number of policies that required notice and comment and became effective in Workload 2. Report the number of policies that were presented for notice and comment in Workload column 3.

Law Enforcement Activities (Activity Code 21009)

Carriers may receive requests from the OIG, or other Federal agencies, State, or local law enforcement for data and documents related to potential or ongoing audits, civil or criminal health care fraud investigations. The carrier must follow the Program Integrity Manual when addressing these requests.

For work done to support law enforcement, report all medical review and related data analysis costs in CAFMII Activity code 21009. Report number of claims reviewed in workload Column 1. Report number of medical review data analysis requests in workload Column 2. Report the number of law enforcement requests in workload Column 3.

Other Activities

Carriers must work with any and all Program Safeguard Contractors (PSC), or other entities that contract with HCFA.

SUMMARY OF MEDICAL REVIEW CAFM II ACTIVITY CODE DEFINITIONS FOR INTERIM EXPENDITURE REPORTS

Activity Code	Review Type	Workload 1	Workload 2	Workload 3
21001	Automated Review	Claim denials in whole or in part	Claim denials in whole or in part	Line items denied in whole or in part
21002	Routine Manual	Claims reviewed	Claims denied in whole or in part	Line items denied in whole or in part
21003	Complex Manual	Claims reviewed	Claims denied in whole or in part	Line items denied in whole or in part
21004	Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21005	On-Site Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21006	In-House Postpay Reviews	Claims reviewed	Claims denied in whole or in part	N/A
21007	Data Analysis (Costs only)	N/A	N/A	N/A
21008	Policy Development	N/A	Number of policies Requiring notice and comment that Became effective during the month	Number of policies presented for notice and comment during the month
21009	Law Enforcement	Claims reviewed	Number of MR Data Analysis requests	Number of law enforcement requests

SUPPORTING DOCUMENTATION FOR FY 2001 BPR REQUESTS

Any increase in funding from FY 2000 base activities, as required in the FY 2001 BPR, must be accompanied by the following information in order for the appropriate funding decisions to be made. Include the identification of any new BPR activities that may cause increase in funding from the FY 2000 base activities.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Medicare Secondary Payer (Carrier)

THESE REQUIREMENTS STAND ALONE AND SUPERSEDE PRIOR YEARS BPRS

There has been a change in the contractor community during this past year. That change, which includes the establishment of a Coordination of Benefits (COB) Contractor to handle all front end MSP activities, will cause a change in the work flow for MSP contractor pre-pay and post-pay activities. Additionally, intermediaries and carriers no longer have any dollar tolerance (that is, there is a zero tolerance amount) for MSP development and have no recovery tolerances except for Group Health Plan (GHP) recoveries. Contractors are reminded that there is no backend tolerance for GHP recoveries (that is, once a demand is issued, the fact that the amount of the debt falls below $1,000 due to partial payment or some other reason does not permit the case to be closed. The resulting changes are included in the pre-pay and post-pay BPRs set forth below.

These BPRs presume funding for ongoing activities. In general, these MSP activities are described in the following sections of the Medicare Intermediary Manual (MIM)/Medicare Carrier Manual (MCM) or the successor sections and in the specific instructions contained in the communications identified below. Where the MIM has been updated and the MCM has not, carriers should follow the policy in the updated manual (recognizing that some of the operational terms may not translate exactly for carriers).

Working Aged	MCM 4301, 3336
Disabled	MCM 3337
Workers' Compensation	MCM 3330, 2370
Liability and No-Fault	MCM 4320, 3338, 3340 MIM 3418
ESRD	MCM 4303, 3335
MSP Standard Software	MCM 4306
MSP Common Working File	MCM 4307, 4308
Recovery of Mistaken Payments	MCM 3375
MSP Savings Reports	MCM 13450

Guidance you received from your regional office based on our August 28, 1996 memo titled "Use of Employer Demand Letters to Protect HCFA's Legal Rights in IRS/SSA/HCFA Data Match Recovery Cases" from Lisa Vriezen to All Associate Regional Administrators for Medicare ("First" August 28, 1996 memo).

Guidance you received from your regional office based on our August 28, 1996 memo titled "Clarification of FY 1997 Budget and Performance Requirements (BPRs) Concerning Medicare Secondary Payer MSP Recovery Periods from Lisa Vriezen to All Associate Regional Administrators for Medicare Secondary August 28, 1996 Memo).

Guidance you received from your regional office based on our November 25, 1996 memo titled, ARecent Court Orders in Health Insurance Association of America v. Shalala and Revised Operating Instructions≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare. **(This memo includes front-end tolerances for GHP recoveries.)**

Guidance you received from your regional office based on our December 19, 1996 memo titled, AResponses to Contractor and Regional Office Questions Generated Regarding Implementation of November 25, 1996 Revised Operating Instructions Issued Subsequent to Court Orders in Health Insurance Association of America v. Shalala≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare.

Guidance you received from your regional office based on our August 29, 1997 memo titled, AMSP: Group Health Plan Recovery Demand Letter to Employer Language≅ from Lisa Vriezen to All Associate Regional Administrators for Medicare.

Program Memorandum AB 98-6 dated March 27, 1998 (reissued as AB 98-68 dated November 1998) entitled AIdentifying Employer in Other than Data Match Group Health Plans - Medicare Secondary Payer Recovery Situations.≅

MSP PRE-PAY ACTIVITIES - (ACTIVITY CODES 22001 and 22005)

Note: Program Memorandum (CR #1163, AB-00-36) provides further detail on the changes set forth below (including details on any record layouts) was issued May 1, 2000 for implementation on October1, 2000 and is currently being revised for implementation on January 1, 2001.

Effective 1/1/2001, FY 2001 BPRs reflect major work changes from the FY 2000 BPRs, due to the transfer of pre-pay development functions to the COB contractor. With the establishment of the COB contractor, intermediaries will no longer perform First Claim Development (FCD) when the intermediary receives a first claim for a beneficiary. Carriers will no longer perform Trauma Code Development (TCD) when a claim is submitted with a diagnosis code that indicates the possibility of other coverage, primary to Medicare, for an accident/injury or illness.

Two of the activities, "updating HCFA records timely and electronic requests and referrals for COB contractor update of HCFA records" and " electronic requests and referrals to the COB contractor for MSP record deletions (and/or further investigation, if appropriate)" set forth intermediary authority as of 1/1/2001 regarding adding, updating, and deleting MSP auxiliary records on the Common Working File (CWF). These are new functional parameters for carriers as a result of the COB contractor.

The following MSP pre-pay activities are listed in order of priority. This order of priority is effective until 12/31/2000. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Update HCFA records timely.
2. Develop the first claim submitted on behalf or by the beneficiary which is identified by the CWF "Z" trailer.
3. Special Projects (includes litigation support).

1. Updating HCFA Records Timely (Activity Code 22001)

Upon receipt of information that may affect Medicare's status as a primary or secondary payer (i.e. correspondence from attorneys, beneficiaries, third party payers, or another insurer's EOB) evaluate the information and determine its effects on Medicare payment status. If warranted, update CWF within 10 calendar days from completion of evaluation or within 30 calendar days from receipt of the information from any informational source, whichever is less.

2. First Claim Development (FCD) (Activity Code 22001)

Develop the first claim, submitted by or on behalf of the beneficiary, which has been identified by a "Z" trailer in CWF. The FCD letter should be sent to the beneficiary. At present there are five existing FCD letters found in the MCM but only the most appropriate letter should be sent. No follow-up mailings should be initiated based on the absence of a beneficiary response. Negative responses should not be entered into CWF.

3. Trauma Code Development (Activity Code 22001)

For liability, no-fault, and workers' compensation, carriers will initiate development on all trauma codes as outlined within the various sections of the MCM. Development is not required on each bill received which is representative of the same beneficiary occurrence. TCD should continue via the HCFA L-365,

Report to Medicare of Automobile or Liability Insurance Coverage, or an alternative development letter or form that has been approved for use by the carriers' RO.

4. Special Projects (Activity Code 22001)

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

The following MSP pre-pay activities are listed in order of priority. This order of priority is effective is 1/1/2001. ALL OF THESE ACTIVITIES ARE MANDATORY.

1) Updating HCFA records timely and electronic requests and referrals for COB contractor update of HCFA records.

2) Electronic requests and referrals to the COB contractor for first claim development issues.

3) Electronic requests and referrals to the COB contractor for liability, no-fault, and workers' compensation cases.

4) Electronic requests and referrals to the COB contractor for MSP record deletions (and/or for further investigation, if appropriate).

1. Updating HCFA Records Timely and Electronic Requests and Referrals for COB Contractor Update of HCFA Records (Activity Code 22001)

Effective 1/1/2001, carriers should discontinue updating the CWF, with the following exceptions:

A. When the carrier receives a phone call or correspondence from an attorney, beneficiary, third party payer, provider, another insurer's EOB or other source that establishes, -- exclusive of any further required development or investigation -- that MSP no longer applies (e.g., beneficiary or spouse has retired), the carrier should post a termination date to the MSP auxiliary record. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of telephone call.

B. When the carrier receives a secondary claim that includes sufficient data (e.g., EOB) to warrant adding an MSP auxiliary record, the carrier should add the MSP occurrence using an "I" validity indicator.

C. When the carrier determines that an unsolicited refund is MSP based and the referral document contains sufficient information to create an "I" record without further development, the carrier should add the MSP occurrence using an "I" validity indicator. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of telephone call.

D. You receive a claim for conditional payment and the claim contains sufficient information to create an "I" record without further development. You must add the MSP occurrence using an "I" validity indicator. Update
CWF within 10 calendar days from completion of the evaluation.

The above four instances are the only instances in which the carrier has the authority to update the CWF. For all other instances, the carrier must submit an electronic referral to the COB contractor, using the COB contractor Electronic Correspondence Referral System. Depending on the situation, these electronic referrals will take the form of either a CWF assistance request or an MSP inquiry.

For CWF assistance requests or MSP inquiry referrals, information should be electronically forwarded within 20 calendar days of mailroom date stamped receipt, or date of telephone call. If requested, carriers must fax to the COB contractor within 5 business days of request a copy of any correspondence or substantiating information related to the electronic referrals.

2. Electronic Requests and Referrals to the COB Contractor for First Claim Development (FCD) Issues (Activity Code 22001)

Effective 1/1/2001, carriers will no longer be responsible for first claim development. The first claim submitted to Medicare by or on behalf of a beneficiary will be developed by the COB contractor. FCD letters that are received by carriers on or after 1/1/2001 should be forwarded to the COB contractor within 20 calendar days of mailroom date stamped receipt. Any information the carrier plans to transmit to the MSP auxiliary file for FCD letters received prior to 1/1/2001 must be transmitted to CWF by 1/1/2001. Any requests for changes after that date must be submitted through the COB Contractor Electronic Correspondence Referral System. Carriers must use the electronic CWF assistance request.

3. Electronic Requests and Referrals to the COB Contractor for Liability, No-Fault, and Workers'Compensation Cases (Activity Code 22001)

Effective 1/1/2001, carriers will no longer be responsible for trauma code development (TCD), through the use of the L-365 or any other TCD tool. Claims that are received which contain an ICD-9 code as listed within the MIM will be developed by the COB contractor. The following additional procedures apply:

A. TCD letters that are received by Medicare carriers on or after 1/1/2001 should be forwarded to the COB contractor within 20 calendar days of mailroom date stamped receipt.

B. When an carrier receives information from an attorney, beneficiary, provider, or liability carrier or other source which establishes, exclusive of any further required development or investigation, that MSP no longer applies (e.g., personal injury protection exhausted), the carrier should post a termination date to the MSP auxiliary record. Update CWF within the lesser of: 1) 10 calendar days from completion of the evaluation, or 2) 30 calendar days of the mailroom date stamped receipt/date of telephone call.

C. The carrier must submit to the COB contractor any information that may necessitate a change/update to the auxiliary record, exclusive of a termination date, using the COB Contractor Electronic Correspondence Referral System. These electronic referrals should constitute either a CWF assistance request or an MSP inquiry. Information should be electronically forwarded within 20 calendar days of the mailroom date stamped receipt or phone call date. If requested, carriers must fax to the COB contractor within 5 business days of request, a copy of any correspondence or substantiating information related to the electronic referrals.

4. Electronic Requests and Referrals to the COB Contractor for MSP Record Deletions (and/or Further Investigation, If Appropriate) (Activity Code 22001)

When a carrier discovers, through the receipt of documentation from a beneficiary, provider, group health plan, attorney, or other source, that there is an erroneous MSP record on CWF, the carrier should request that the record be deleted using the COB Contractor Electronic Correspondence Referral System. Carriers must use the electronic CWF assistance request to request a deletion. Information should be electronically forwarded within 20 calendar days of mailroom date stamped receipt. If requested, carriers must fax within 5 business days of request, a copy of any correspondence or substantiating information related to the electronic referrals.

Workload

The Prepayment workload (Workload 1 in CAFMII) for Activity Code 22001 is the cumulative workload reported on Line 1, Total Column, of the HCFA-1564.

MSP POSTPAYMENT CLAIMS (ACTIVITY CODES 22002 and 22003)

The following MSP post-pay activities are listed in order of priority. This order of priority is effective until 12/31/2000. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Pursue recovery of identified primary mistaken payments.

2. MSP adjustment process.
3. Special projects (includes litigation support).

1. **Pursue recovery of identified primary mistaken payments.**

A. **Liability, No-Fault, Workers= Compensation - Code 22002**

Contractors are reminded that they must develop further and pursue recovery whenever they receive information that a beneficiary, provider, physician, or other supplier is pursuing a claim against workers= compensation insurance, no-fault insurance or liability insurance. In recovery situations, contractors must cooperate with the lead contractor (if they are not the lead contractor), in all instances, regardless of the amount the non-lead contractor has at issue.

1) If the contractor has specific information from any source that workers= compensation insurance or no-fault insurance has acknowledged primary payment responsibility or that liability insurance has either made payment or acknowledged liability with respect to services that may have been provided to a Medicare beneficiary, the contractor must develop for any additional needed information and pursue recovery of Medicare=s repayment claim in all cases. Sources that may provide such information include providers, physicians or other suppliers, beneficiaries, attorneys, insurers, etc. The contractor must also develop if it receives a general inquiry about services provided to a Medicare beneficiary from workers= compensation insurance, no-fault insurance or liability insurances or an attorney representing one or more of these insurers or a specific beneficiary. There are no development or recovery tolerances in these instances.

2) If the contractor receives information from a beneficiary, attorney, insurance company, provider, supplier, or any other entity that a beneficiary---or some other entity acting on behalf of the beneficiary under a subrogation right---is/will pursuing a claim against a tort-feasor and/or his/her liability insurance, workers= compensation insurance or, no-fault insurance (in a L-365 response, letter, phone call, e-mail, etc), the contractor is obligated to develop further with the appropriate parties and pursue recovery. There are no development or recovery tolerances in these instances.

NOTE: The submission of an L-365 with a Anegative≅ response does not negate the requirement for development when subsequent information is received from another source which indicates pursuit of a claim.

3) If the contractor receives information from any source that workers= compensation, no-fault or liability insurance may have primary payment responsibility for services provided to a specific Medicare beneficiary, the contractor must develop for more information (manually or otherwise) and pursue recovery when either of the following conditions or circumstances are present:

a. A claim form indicates that services were work or accident related and the amount of the Medicare payment for these services is $500.00 or more even if there is no procedure codes indicating trauma.

The contractor must develop with the provider/supplier that submitted the claim or the beneficiary, as appropriate, and pursue recovery of any identified Medicare repayment claim.

If the development reveals that a claim is being pursued against workers= compensation insurance, no-fault insurance, or liability insurance (or tort-feasor), the contractor must follow the rules in 1.a.2. above.

b. A claim form indicates that services were work or accident related and the amount of the Medicare primary payment for these services is less than $500.00.

The contractor must: (1) search its claims history and CWF claims history with respect to claims processed by other contractors and determine if there are other claims that may be related to the claim linked to work or accident related services; (2) add the Medicare payment amounts on the claims identified in the preceding step; (3) if the total Medicare payment amount computed in the preceding step is $500 or more, develop with the appropriate entities.

If the development reveals that a claim is being pursued against workers= compensation insurance, no-fault insurance, or liability insurance (or tort-feasor), the contractor must follow the rules in 1.a.2. above.

Note: Contractors may lower the development tolerance (in item 3.b.) is cost-effective.

A. Non-Data Match Group Health Plan - Code 22002

1) If a group health plan specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make a primary payment, recover the Medicare primary payment from the group health plan or the appropriate party (beneficiary, provider or supplier).

2) In the absence of such specific information, a contractor is obligated to search history if it receives information on a claim form, in response to a development letter, or otherwise that an MSP situation may exist, with respect to services to an identified beneficiary provided on or after August 5, 1997. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

If the history search identifies potential mistaken primary payments that equal or exceed $1000, the contractor is obligated to seek recovery by sending a demand letter to the employer that sponsors or contributes to the group health plan. Carriers are not to recover from the supplier, unless the supplier has received a duplicate primary payment from the group health plan and Medicare.

See the regional office instructions based on the Lisa Vriezen memos dated August 28, 1996, November 25, 1996, December 15, 1996, August 29, 1997, and PM AB 98-6 (reissued as AB 98-68 dated November 1998.)

C. **Recoveries from IRS/SSA Data Match - Code 22003**

See the regional offices instructions based on the Lisa Vriezen memos dated November 25, 1996 and the August 29, 1997 but make the following changes:

1) Change the date from January 1, 1997 to August 5, 1997 wherever the January 1, 1997 date appears. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

2) Amend the next to last sentence in item 2(a)(ii) on page 2 of the November 25, 1996 memo to read, ASend an initial demand letter within 60 days of receipt of a Data Match cycle tape from HCFA or its agent, to the employer. Carriers are not to recover from the physician or other supplier, unless the physician or other supplier has received a duplicate primary payment from the group health plan and Medicare.

The contractor is to update MPARTS within 10 calendar days from completion of evaluation or within 30 calendar days from receipt of information, whichever is less.

2. **Special Projects (MSP Prepay and Postpay activities 22001 through 22006)**

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

MSP POST-PAY ACTIVITIES (ACTIVITY CODES 22002 and 22003)

The following MSP post-pay activities are listed in order of priority. This order of priority is effective is 1/1/2001. ALL OF THESE ACTIVITIES ARE MANDATORY.

1. Pursue recovery of identified primary mistaken payments, including recoverable conditional payments.
2. MPaRTS updates.
3. Special projects (includes litigation support).

1. Pursue Recovery of Identified Mistaken Primary Payments, Including Recoverable Conditional Payments (Activity Codes 22002 and 22003)

A. Notices/Inquiries –

1) As stated in the MSP pre-pay BPRs, effective 10/1/2000, carriers will only have authority to update CWF in a limited number of situations. It is important that carriers understand what this means with respect to the notices or inquiries they have routinely received in the past and which they used as the basis for further development or other action for MSP recoveries.

2) For written correspondence and telephone calls:

a) If it is clear that the correspondence is an initial contact for a potential recovery case,

(i) for correspondence, the inquiry/correspondence should be transferred to the COB contractor using the COB contractor Electronic Correspondence Referral System.

(ii) for telephone calls, the call must be transferred to the COB contractor at the time of the call or the information must be submitted to the COB contractor using the COB contractor Electronic Correspondence Referral System.

b) If it is clear that the correspondence or telephone call is a further question or information regarding an established case, the intermediary should handle it under its normal procedures if it has responsibility for the case or transfer it to the appropriate contractor if another contractor has responsibility for the case. "Established case" means an established MSP case – with the exception of certain HCFA identified class actions or groups, this means that there will be an established MSP record in CWF.

c) If it is not clear whether or not the correspondence or telephone call is an initial contact for a potential recovery case, CWF should be checked. The resulting information should be used to handle the correspondence under #1 or #2 above, as appropriate.

B. Liability, No-Fault, Workers' Compensation, Federal Tort Claims Act Recoveries (Activity Code 22002)

1) Designated lead contractors for liability, no-fault, and workers'compensation recoveries –

a) For liability or no-fault recoveries, the lead contractor will generally be an **intermediary** for the State of the beneficiary's residence. National intermediaries may be assigned a State(s) where they have a significant workload. The list of lead contractor assignments can be found in Attachment 7. "Beneficiary residence" will be determined by the existing CWF rules for beneficiary residence. The lead will remain with the initial lead contractor even if the beneficiary subsequently changes his/her permanent residence.

b) For workers' compensation recoveries, the lead contractor will be the same as the lead contractor would be for a liability or no-fault recovery **except** where venue for the workers' compensation claim is in a different State. In this situation, if the beneficiary and/or his attorney or other representative identifies the State of venue at the time of the original inquiry or other notification (through an L-365 or some other communication), the COB contractor will forward the lead to the designated intermediary for the State of venue. If a contractor has the lead based upon the State of the beneficiary's residence and it is subsequently determined that the State of venue is a different State, the initial lead intermediary will transfer the lead to the designated intermediary for the State of venue. Note: the State of venue is the State under whose rules the workers compensation case is being adjudicated.

c) HCFA may continue to designate a specific lead contractor for a particular group or class of recoveries (for example, as HCFA has done for certain product liability recoveries).

d) For FTCA cases, the lead contractor will be the same as the lead contractor would be for a liability or no-fault case. Please note that although a lead contractor is being designated for FTCA cases, these recoveries will continue to be the responsibility of HCFA Central Office (CO) staff. The responsibility of a lead contractor for FTCA cases will be to identify Medicare's recovery claim amount and to coordinate/facilitate communications with other intermediaries and carriers, as required by HCFA CO.

e) These requirements concerning designated lead contractors apply to all cases where the MSP record is established through the COB process as specified in the MSP pre-pay BPRs. It is critical that lead contractors have any applicable MSP records established for existing cases by 1/1/2001. Established cases will not be transferred on the basis of these new criteria.

f) **Please note that under these new rules, a carrier will only be the lead contractor for a new MSP case when HCFA specifically designates this responsibility to the carrier**.

g) Both lead and non-lead contractors must cooperate and coordinate with the COB contractor, as appropriate.

h) When the lead contractor receives information from the COB contractor that workers= compensation, no-fault, or liability insurance may have primary payment responsibility for services provided to a specific Medicare beneficiary, the lead contractor must develop, as appropriate, and pursue recovery. (Note: The COB contractor will issue the initial notice of potential Medicare recovery letter and request any necessary beneficiary release(s) in conjunction with this notice.)

i) If the MSP occurrence has been established in CWF but the lead contractor decision has not been made as of January 1, 2001, the affected contractors should use the list of lead contractors and confirm with the designated lead contractor that it has responsibility for the case and issue. As stated above, if the MSP occurrence has not been established as of January 1, 2001, the instructions for referral to the COB contractor (including the forwarding of all associated documents to the designated lead contractor) must be followed.

2) Intercontractor Notices (ICNs):

a) Non-lead contractors must co-operate with lead contractor ICN requests.

b) Non-lead contractors must respond to initial and interim ICN requests within 30 calendar days of the receipt of the request (corporate mail stamp date). The lead contractor may grant a 15-day extension, if appropriate.

c) Non-lead contractors will have 10 days to respond to a final ICN update request once there has been a settlement, judgment, or award.

d) A beneficiary release is not required in order for a non-lead contractor to respond to the ICN of the lead contractor.

C. Non-Data Match Group Health Plan (GHP) Recoveries (Activity Code 22002)

1) If a GHP specifically acknowledges that Medicare made a mistaken primary payment for a specific service and specifically acknowledges that it should have or did make a primary payment, recover the Medicare primary payment from the GHP or the appropriate party (physician or other supplier or beneficiary). Send the recovery demand letter within 30 calendar days of receiving the GHP acknowledgement.

2) In the absence of such specific information, within 60 days of the establishment of a new CWF MSP auxiliary record by the COB contractor, a contractor is obligated to search history within the established MSP period and send a demand letter (if the history search identifies potential mistaken primary payments that equal or exceed $1000) to the employer which sponsors or contributes to the GHP. Carriers are not to recover from the physician or other supplier unless the physician or other supplier has received a duplicate primary payment from the GHP and Medicare.

See the regional office instructions based on the Lisa Vriezen memos dated August 28, 1996, November 25, 1996, December 15, 1996, August 29, 1997, and PM AB 98-6 (reissued as AB 98-68 dated November 1998.)

D. Data Match GHP Recoveries (Activity Code 22003)

1) See the regional office instructions based on the Lisa Vriezen memos dated November 25, 1996 and the August 29, 1997, but make the following changes:

a) Change the date from January 1, 1997 to August 5, 1997 wherever the January 1, 1997 date appears. Due to the enactment of the Balanced Budget Act of 1997 (BBA 1997), for all services on or after August 5, 1997, Medicare has a minimum of 3 years to initiate recovery without regard to a plan=s timely filing requirements.

b) Amend the next to last sentence in item 2(a)(ii) on page 2 of the November 25, 1996 memo to read, ASend an initial demand letter within 60 days of receipt of

a Data Match cycle tape from HCFA or its agent, to the employer. Carriers are not to recover from the physician or other supplier unless the physician or other supplier has received a duplicate primary payment from the group health plan and Medicare.≅

2) MPaRTS update:

a) The contractor is to update MPaRTS, as appropriate, depending on the factual situation, within the lesser of: 1) 30 calendar days from receipt of a response to a data match demand letter or other information affecting a data match case; or 2) 10 calendar days from completion of the evaluation of the information received relevant to the case.

b) Clarification of the 10 and 30 calendar days: 1) contractors must update MPaRTs with the appropriate code within 10 calendar days of the run date of a Data Match cycle tape; 2) the date the information is received by the contractor (most often reflected by a date-stamp in the contractor's corporate mailroom) would act as the start date when information is received through the mail; and 3) the date of the call would act as the start date when information is received by telephone. Where the start date is the mail receipt date, the initial receipt date by the contractor is controlling. (Example: Mail is received in the contractor mailroom on 12/1/99 and by the MSP unit on 12/3/99. The start date is 12/1/99. This would be true even if the contractor's mailroom is at a different address than the location where the inquiry or other information is processed.)

2. Special Projects - MSP Prepay and Postpay activities 22001 through 22006

Implement special MSP projects pursuant to specific instructions that HCFA may issue.

Workload

The Postpayment workload (Workload 1 in CAFMII) for Activity Code 22002 is the cumulative workload reported as the sum of Line 3 plus Line 5, Total Column of the HCFA-1564.

The Recoveries from IRS/SSA Data Match (Activity Code 22003) workload unit of measure for Data Match is the report identification (RI) number. This is the number used in the Mistaken Payment Recovery Tracking System (MpaRTS). Report this workload (Workload 1 in CAFMII) when all claims associated with a RI number have been:

- Researched and a demand letter issued.
- Researched and no further action can be taken at this time because of dollar tolerances.
- Researched and a determination is made that there are no claims Medicare paid as primary or your records do not indicate any claims; or
- Researched and the contractors can take no further actin on a RI number because of pending litigation or other instructions by HCFA to suspend recovery actions.

MSP - INQUIRIES - (ACTIVITY CODE 22004)

Include the costs associated with pre-pay and post-pay MSP inquiry activities.

The MSP Inquiries workload is the cumulative sum of telephone and written inquiries responded to by the MSP staff.

MSP - OUTREACH - (ACTIVITY CODE 22006)

Include the costs associated with pre-pay and post-pay MSP outreach activities.

The MSP Outreach workload is the cumulative number of outreach presentations performed.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Benefit Integrity (Carrier Including DMERCs)

Our Program Integrity goal is to strive in **every** case to pay the right amount to a legitimate provider for covered, reasonable, and necessary services provided to an eligible beneficiary. To achieve this goal, we follow four parallel strategies: 1) preventing waste, fraud, and abuse through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, fraud detection tools and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

Additionally, contractors should continue to develop and successfully implement the following during FY 2001. An enhanced Benefit Integrity (BI) staff program that will attract, train, and retain qualified professional staff in the BI area. Fraud investigators are required to take Level I and Level II training. Level I training should be completed one time only, and within one year of hire for new employees and within one year of this BPR for current employees who have not previously completed this training. Level I training consists of a total of 36 hours: 16 hours of fraud detection techniques; 4 hours of interviewing techniques; and 16 hours of data analysis. Fraud investigators who have completed Level I training before FY 2001 must complete Level II training during FY 2001. Level II training consists of a total of 6 hours of advanced training; 4 hours of fraud detection techniques; and 2 hours of advanced data analysis. This Level II training will be required each fiscal year. Additionally, the BI unit must send appropriate representatives to the national benefit integrity training hosted by HCFA. The OIG report OEI-05-94-00470, dated November 1996, noted that most carrier fraud units developed few cases proactively and did not identify program vulnerabilities. (Vulnerabilities are defined as situations where questionable and improper Medicare payments are being made because of a legal loophole or because of systems' limitations that can't be corrected by the contractor. Individual fraud cases should not be reported as Program vulnerabilities. Vulnerability reports should be submitted to the HCFA CO and RO.) You must continue implementation of a Quality Improvement (QI) program. The QI program must ensure that the decisions made by the fraud unit are effective in preventing, detecting, and deterring Medicare waste, fraud, and abuse; and that appropriate corrective actions have been employed for systemic problem areas. We suggest that the contractor conduct routine follow-ups to ensure that the corrective actions are accomplishing the goals. In addition, timely actions are essential to ensure the efficiency and effectiveness of the Program. Delayed corrective actions may: 1) permit an unsafe situation to prevail, 2) de-emphasize the seriousness of the problem, and 3) diminish the deterrent effect. Contractors must submit a report of findings for the QI program. This report must be submitted 30 days after the close of the second and fourth quarters. This report must be entitled "Benefit Integrity Quality Improvement Program." The report must be submitted to the regional office and copied to the central office at POB@cms.hhs.gov . We expect the contractor's budget request to reflect these priorities.

The BI Budget and Performance Requirements (BPRs) are the basis for the Contractor Performance Evaluation (CPE) for Benefit Integrity Units. The BI BPRs represent the increased focus on prevention, early detection, and multi-component and agency coordination. HCFA=s national objectives and goals of the CPE are: 1) Identify and use a variety of methods to detect and identify fraudulent activities; 2) Increase the use of a variety of methods, in addition to referral to law enforcement, to protect the Medicare Trust Fund in potentially fraudulent or abusive situations; 3) Improve the quality of case referrals to law enforcement; and 4) Improve the working relationships between contractors and law enforcement.

Although many of the safeguard activities are located in the BI unit, the contractor as a whole is responsible for protecting the Medicare Trust Fund against waste, fraud and abuse. Carrier budget requests should ensure implementation of all BI program requirements in MCM 14000ff or the future Program Integrity Manual in addition to those specified in this document.

Each carrier should provide the supporting documentation requested in Attachment 6 of the FY 2001 BPRs. Attachment 6 requests contractor specific narrative, workload, and cost data for FY 2000 and FY 2001.

Medicare Fraud Information Specialist MFIS (Activity Code 23001):

The MFIS has overall coordinating responsibility for ensuring that fraud-related information is shared with appropriate parties in their assigned areas. The MFIS should conduct regular conference calls (on an individual basis or as a group) with all contractor Fraud Unit Managers within their jurisdiction. In addition, contractors who do not have an MFIS located onsite are responsible for fully utilizing the services of the MFIS assigned to them. The MFIS should be helpful setting up meetings with provider and beneficiary groups and in obtaining presenters from other agencies and materials for these discussions. The MFIS is also responsible for the dissemination of information and networking with HCFA=s partners. The MFIS should focus on support and training for Harkin Grantees.

The MFIS should not perform activities such as complaint resolution, case development, OIG Hotline referrals, FID entries, data analysis, IRP entries, or onsite audits.

For clarification of the MFIS position description, RO accountability, and MFIS assignment, refer to CR 1172, effective October 1, 2000.

Report all costs associated with MFIS activity in Activity Code 23001. (This applies only to contractors who are currently funded for the MFIS position; no new MFIS positions will be funded.) Your FY 2001 budget request should include your work plan and level of activity for all training and outreach functions.

Report the number of fraud conferences/meetings coordinated by the MFIS in workload column 1; the number of fraud conferences/meetings attended by the MFIS in workload column 2; and the number of training sessions performed for law enforcement, ombudsmen, Harkin Grantees and other grantees, and other HCFA health care partners in workload column 3.

Fraud Complaint Development and Other Lead Activities (Activity Code 23002):

Only fraud complaint development costs should be included in this activity (do not include any case development costs in this activity). Once the initial complaint has been closed, if

additional costs are incurred to develop a case related to that complaint, those additional costs should be charged to Activity Code 23005.

The BI unit should take all necessary actions to fully develop, consistent with work priorities, potential fraud leads (e.g., fraud alerts, internal and external contractor referrals, Office of Inspector General (OIG) hotline calls, Fraud Investigation Database (FID) leads, and fraud complaints such as Operation Restore Trust (ORT) referrals from the States or Regions).

A fraud complaint is an allegation of fraud or abuse committed by a provider, beneficiary, or other individual or entity against the Medicare program.

The BI unit should only receive and develop complaints that are likely to indicate fraud and abuse situations. The clearinghouse function (i.e., screening of incoming inquiries: written, telephone, or walk-in) must not be performed by the BI unit, but costs can be allocated to BI if they are fraud related. The BI unit should return to the appropriate contractor unit (e.g., Customer Service unit) any complaints that are not fraud and abuse situations. Refer to MCM 14020.1 for acknowledgement of complaints.

Note: Each contractor must use the AIRP (Incentive Reward Program) tracking database≅ to support receiving and tracking fraud and abuse complaints related to the incentive reward program.

Report all costs associated with fraud complaint development in Activity Code 23002. Report the number of fraud complaints alleging waste, fraud, and abuse referred to the BI unit in workload column 1, the number of fraud complaints closed in workload column 2, and report the number of workload column 2 fraud complaints which resulted in an overpayment collection in workload column 3.

Outreach and Training Activities (Activity Code 23004):

Include costs associated with establishing and maintaining waste, fraud, and abuse outreach and training activities for beneficiaries (excluding MFIS). Beneficiary outreach activities are described in MCM section 14023. Beyond the activities in 14023, training activities are limited to:

< Providing waste, fraud, and abuse training to new and existing BI fraud unit contractor staff.

< Providing waste, fraud, and abuse training to non-BI contractor staff.

< Participating in training developed for law enforcement agencies, including the Federal Bureau of Investigation.

< Providing waste, fraud, and abuse outreach presentations to beneficiaries (including respective associations).

Report all costs associated with waste, fraud, and abuse outreach and training activities for contractor staff and beneficiaries in Activity Code 23004. Report the number of training sessions furnished only to BI staff in workload column 1, the number of face-to-face presentations made to beneficiaries in workload column 2, and the number of training sessions furnished to non-BI contractor staff in workload column 3. Provider education and training activities related to Medicare Integrity Program (MIP) activities can be performed by BI, but costs must be reported on the MIP-PET line.

Note: 1) a training session is the presentation of a topic regardless of the number of attendees; 2) a training session which exceeds more than one day is counted as one session; and 3) the same training session which is repeated at a later date should be counted as a separate session.

Fraud Case Development Activities (Activity Code 23005):

A case exists when the contractor has substantiated an allegation that a provider, beneficiary, supplier, or other subject: (a) is suspected of intentionally engaging in improper billing, (b) submitted improper claims with actual knowledge of their falsity; or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. The contractor's substantiation of the allegation is the verification of the information. However, it is not the proving of the information in a court of law. Contractors do not prove fraud, this action is within the purview of the Department of Justice. This determination is made regardless of dollar threshold or subject matter.

In addition to developing a case based on complaints and other leads outside the contractor environment, the BI unit is expected to perform proactive data analysis (MCM 14003.3C) by concentrating efforts on those areas that have the highest impact for potential fraud; and self-initiating, fully developing, and referring potential fraud cases to law enforcement. Fraud case development must follow the guidelines in MCM 14000ff, and include the use of a proactive data-based analysis to identify patterns of potential waste, fraud, and abuse. The development and referral of potential fraud cases to law enforcement must be accomplished in a way compatible with the contractor=s mission of minimizing losses attributable to waste, fraud, and abuse to the Trust Fund.

Report any costs associated with fraud case development and FID entries in Activity Code 23005. Report the total number of cases opened in workload column 1. Of the cases reported in workload column 1, report how many were opened by the contractor based on the contractor's self-initiated proactive data analysis in workload column 2. Report the total number of cases closed (no longer requiring fraud development) and which were not referred to Office of Investigations Field Office (OIFO) in workload column 3. Referred cases are defined as those meeting the requirements of MCM 14009. Matters should be referred to the OIG when the contractor has a reasonable basis to suspect that the provider (a) intentionally engaged in improper billing, (b) submitted improper claims with actual knowledge of their falsity, or (c) submitted improper claims with reckless disregard or deliberate ignorance of their truth or falsity. The OIG has 90 calendar days to accept the referral or reject the case. Whenever the contractor contacts the OIG to inquire whether the OIG will accept a case referral, the contractor should document the call as a referral in the FID, including subsequent acceptance or rejection documentation of the case. (The first call should be documented as a referral; subsequent calls are follow-ups.)

Law Enforcement Support Activities (Activity Code 23006):

Carriers may receive requests from the OIG, other Federal agencies, State, or local law enforcement for data and documents related to potential or ongoing audits, civil or criminal health care fraud investigations. All non-routine requests from law enforcement for carrier assistance should be in writing. The request should outline the specific task and level of effort to be performed by the carrier and the associated law enforcement project/case number. If the number cannot be associated with the request, the carrier should discuss the request with the RO prior to initiating any action.

The carrier should comply with routine written requests from law enforcement for data, documents, and assistance. When a request is received, the carrier should prioritize it based on the type of request (critical request vs. routine request) and the amount of resources it requires. The carrier is encouraged to discuss routine written requests it receives from law enforcement in order to identify the requestor=s specific needs. Such discussions will alleviate any unnecessary burdens on both the carrier and law enforcement agencies.

For work done to support law enforcement, report all BI costs and related data analysis costs in Activity Code 23006. Report the total number of law enforcement requests in workload column 1, report the number of requests discussed with the RO in workload column 2, and report the number of BI law enforcement requests that require data analysis in workload column 3.

Other Activities:

Additional BI unit responsibilities not separately funded or reported above include:

- The FID must be updated on a quarterly basis after the case has been referred to law enforcement.
- Keeping your regional office apprised of significant investigations within your jurisdiction.
- Taking steps to ensure that services provided by or ordered by those persons or entities who have been excluded from Medicare, are not being billed to the Medicare.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Provider Education and Training (Carrier)

The Medicare Integrity Program Provider Education and Training (MIP-PET) Budget and Performance Requirements (BPRs) reflect the principles, values and priorities of the Medicare Integrity Program. Program Integrity's primary goal is to pay claims correctly. In order to meet this goal Carriers must ensure that they pay the right amount for covered services rendered to eligible beneficiaries by legitimate providers. HCFA follows four parallel strategies that assist us in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and post-pay data analysis; 3) close coordination with our partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

The MIP-PET BPR supports the Government Performance Results Act (GPRA) and the National Performance Review (NPR). The GPRA requires that Carriers reduce the error rate identified by the Office of Inspector General's Chief Financial Officer (CFO) audit. Both the GPRA and NPR instruct to increase the effectiveness and improve the efficiency of their Medical Review and Benefit Integrity programs. The FY 2001 BPR supports these goals through provider education and training activities.

Provider Education and Training is divided into two categories: Program Management Provider Education and Training (PM-PET) and Medicare Integrity Program Provider Education and Training (MIP-PET). PM-PET involves activities undertaken in order to prevent billing errors while MIP-PET is remedial and concentrates primarily on providing feedback to providers based on data analysis and medical review results. MIP-PET activities include one on one feedback for provider specific errors; community-wide feedback for widespread errors; and general information about Program Integrity activities. Usually this feedback can be provided best by the Program Integrity component most familiar with the work. For instance, medical review personnel would be able to provide the most accurate feedback concerning issues related to medical review.

The FY 2001 MIP-PET Budget and Performance Requirements concentrate on educational activities that provide feedback to assist all providers and suppliers in the detection and avoidance of waste, fraud, and abuse. It promotes education as a critical aspect in using progressive corrective action to resolving problems identified through medical review and emphasizes the use of data analysis to focus other provider education and training activities.

Costs associated with MIP-PET work products and activities should be charged to Activity Code 24001. This includes MIP-PET activities performed by the medical review and benefit integrity areas. (This code should not be charged for any PM-PET activities.)

REQUIRED MIP-PET ACTIVITIES (Activity Code 24001)

- Provide one on one feedback to individual providers/suppliers on specific problems identified through prepay and postpay medical review. Use progressive corrective action in focusing your educational activities.

- Provide feedback to the larger provider/supplier community on widespread errors. Use data analysis and the results of medical review to direct these educational activities.

- Provide general information about program integrity activities. This includes sharing of information on program integrity goals and processes with local medical societies, professional associations, and other provider/supplier organizations in order to reach as many providers/suppliers as possible.

- Issue bulletins and letters to providers/suppliers containing Program Integrity information. Unless specifically requested by the provider, eliminate special bulletins and letters to all providers/suppliers with no billing activity in the prior 12 months. Bulletins should be posted on contractor websites where duplicate copies may be obtained by providers/suppliers. (Refer to the PM-PET section for posting instructions.) All bulletins/newsletters must have a header/footer that includes the following bolded language: **"THIS BULLETIN SHOULD BE SHARED WITH ALL HEALTH CARE PRACTITIONERS AND**

MANAGERIAL MEMBERS OF THE PROVIDER/SUPPLIER STAFF. Additional copies may be downloaded from our website at (insert contractor website address)."

- Assure prompt, accurate, and courteous replies to all incoming phone calls and letters seeking educational information, clarifications, etc.

- Promote interaction and coordination among the fraud unit, medical review unit, provider/supplier enrollment unit, etc. This interaction and coordination is essential in determining the appropriate training and education that is needed to provide proper feedback to both individual and groups of providers.

OPTIONAL MIP-PET ACTIVITIES (Activity Code 24001)

As time and funding permits the following activities can be funded through MIP-PET.

- Provide remedial education to Administrative Law Judges (ALJs) about Medicare Integrity Program-related policies and administrative procedures.

- As requested participate in presentations at fraud and abuse programs arranged by health care provider/supplier groups.

- Address medical/specialty groups to answer their issues and concerns.
- Prepare/distribute computer based training modules, videos, and other materials that address Medicare Program Integrity issues.

ALLOCATION OF COSTS TO MIP-PET

Regarding any general seminars, conventions, or conferences which address fraud and abuse as well as issues outside the fraud and abuse area, the proportional share of the cost of a function to be allocated to MIP-PET is equal to the percentage of time related to addressing fraud and abuse issues, times the cost of the function.

Regarding any bulletins, letters, inserts, videos, teleconferences, or educational materials which contain fraud and abuse issues as well as issues outside the fraud and abuse area, the proportional share of the cost of any of these items to be allocated to MIP-PET is equal to the percentage of the medium related to addressing frauds and abuse issues times the cost of the letter, bulletin, seminar, etc. (e.g., if it cost $4,000 to produce and distribute a bulletin, containing 25% fraud and abuse information – the MIP-PET cost would be $1,000 and the remaining $3,000 would be charged to PM-PET).

SUPPORTING DOCUMENTATION FOR FY 2001 BUDGET

1. Identify the amount or funding included in the budget related to providing feedback to individual provider/suppliers.

2. Identify the amount of funding included in the budget related to issuing bulletins and newsletters.

3. Identify the amount of funding included in your budget request related to optional MIP-PET activities.

FY 2001 BUDGET AND PERFORMANCE REQUIREMENTS
MEDICARE INTEGRITY PROGRAM

Productivity Investments (Carrier)

Note: The following is provided for carrier information and planning purposes only. Do not request funding for these projects unless specifically requested to do so. Funding will be distributed or Supplemental Budget Requests solicited when appropriate.

MODIFICATIONS TO CARRIER SYSTEMS RESULTING FROM STANDARD SYSTEM MODIFICATIONS FOR MSP CALCULATIONS

Pending N335 (the "N" number is used until a CR # is assigned) instructs the GTE, VIPS, and VIPS DMERC standard systems to accept MSP claims at the line level. This instruction, which was previously released and implemented by other carrier standard systems, is scheduled to be re-released in FY 2000, for implementation beginning 10/1/2000. If N335 is re-released, the users of the GTE, VIPS, and VIPS DMERC systems may require in-house system modifications to interface properly with the modified standard systems. This action will only be required if N335 is re-released. This activity was originally assigned CR #687.